Eating Disorders in Primary Care and Community-Based Clinics: Tools and Resources for the Clinician

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Goals

- Describe how eating disorders present in your practice
- Identify evidence-based tools for detecting eating disorders
- Discuss best practices for eating disorders in primary care and community-based settings

SOCIAL & ECONOMIC COST OF EATING DISORDERS IN THE UNITED STATES

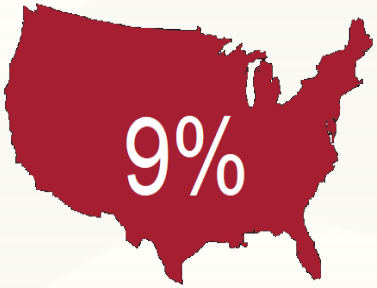
Report by the Strategic Training Initiative for the Prevention of Eating Disorders, Academy for Eating Disorders, and Deloitte Access Economics

STRIPED — A PUBLIC HEALTH INCUBATOR
Strategic Training Initiative for the Prevention of Eating Disorders

LINK TO REPORT

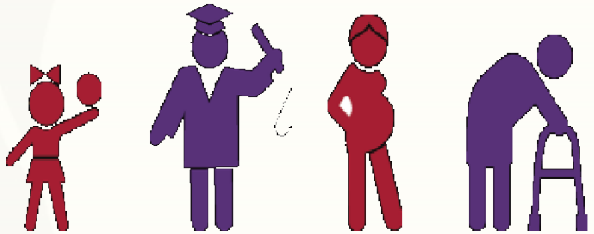
Academy for Eating Disorders (AED)

PREVALENCE & MORTALITY



Percent of the US population, or 28.8 million Americans, that will have an eating disorder in their lifetime

EATING DISORDERS AFFECT EVERYONE:



- All ages, starting as young as 5 years old to over 80 years old
- All races, however, people of color with eating disorders are half as likely to be diagnosed or to receive treatment
- All genders, with females being 2x more likely to have an eating disorder
- All sexual orientations

10,200 deaths per year as a direct result of an eating disorder, equating to 1 death every 52 minutes

NCEED
National Center of Excellence for Eating Disorders

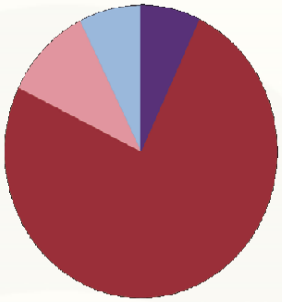
COST TO ECONOMY & SOCIETY

$64.7 Billion } Yearly economic cost of eating disorders

Additional loss of well being per year **$326.5 Billion**

Cost Breakdown:

- Productivity Losses ($48.6B)
- Informal Care ($6.7B)
- Efficiency Losses ($4.8B)
- Health System ($4.6B)



COST TO HOSPITAL SYSTEMS:

53,918 ER visits

costing **$29.3M**

23,560 inpatient hospitalizations

costing **$209.7M**

LOSS PER GROUP:

$23.5B Individuals & Families

Caregivers provide 6 weeks of informal, unpaid care per year

$17.7B Government

$16.3B Employers

$7.1B Society

[1]Somerville KR, Lipson SK. Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. International Journal of Eating Disorders 2018: 1-9.

@HarvardSTRIPED @harvardstriped @STRIPED.Harvard

EDC EATING DISORDERS COALITION FOR RESEARCH, POLICY & ACTION

NEDA Feeding hope. National Eating Disorders Association

IFEDD The International Federation of Eating Disorder Dietitians

THE ALLIANCE for Eating Disorders Awareness

NCEED National Center of Excellence for Eating Disorders

meda multi-service eating disorders association

ANAD YOUR FUTURE IS WORTH FIGHTING FOR

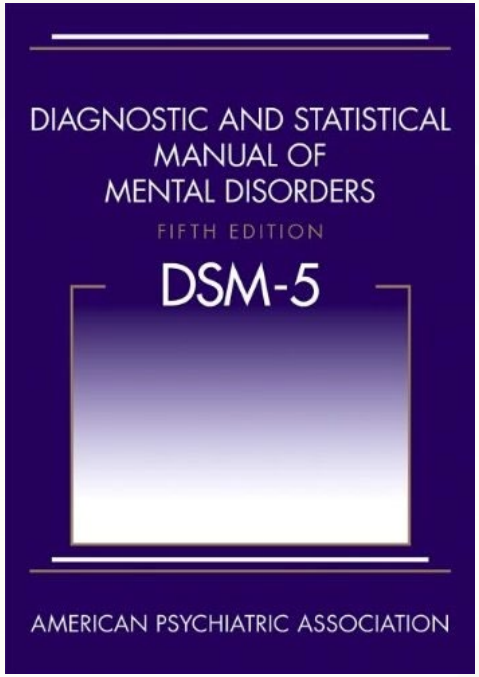
iaedp. Foundation International Association of Eating Disorders Professionals

F·E·A·S·T

REDC Residential Eating Disorders Consortium

Eating Disorders Refresher

How are eating disorders defined/classified?



Diagnoses

- **Other specified feeding and eating disorder (OSFED)**
  - Most common diagnosis
  - Conceptualize as “disordered eating”
- **Binge-eating disorder (BED)**
  - Defining feature: eating an unusually large amount of food accompanied by a sense of loss of control
- **Anorexia nervosa (AN)**
  - Defining feature: intense fear of gaining weight and restriction of energy intake leading to significantly lower weight or precipitous weight loss

Diagnoses

- **Bulimia nervosa (BN)**
  - Defining feature: binge-eating episodes and recurrent inappropriate compensatory behavior (ICB)
- **Avoidant/restrictive food intake disorder (ARFID)**
  - Defining feature: An eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional and/or energy needs

Warning Signs

- Dramatic weight gain or loss
- Frequently talking about food, weight, and shape
- Rapid or persistent decline or increase in food intake
- Excessive or compulsive exercise patterns
- Purging, restricting, binge eating, or compulsive eating
- Abuse of diet pills, laxatives, diuretics, or emetics
- Denial of food and eating problems, despite the concerns of others
- Eating in secret, hiding food, disrupting meals, feeling out of control with food
- Medical complications: dizziness, fainting, bruising, hair loss, brittle hair, osteoporosis, diarrhea, constipation, dental problems,

Common Symptoms and Medical Complications

- **Fatigue and malaise**
- **Temperature dysregulation**
  - Cold/heat intolerance
- **Cardiovascular**
  - Orthostasis, dizziness, syncope, bradycardia
- **Metabolic or electrolyte abnormalities**
  - Hypokalemia, hyponatremia, hypochloremia, alkalosis, ketonuria
- **Endocrine**
  - Amenorrhea, hypogonadism/infertility, osteoporosis, stress fractures

Common Symptoms and Medical Complications

- **Gastrointestinal complaints**
  - Constipation, GERD, IBS, gastroparesis
- **Hematologic**
  - Anemia, leukopenia
- **Vitamin deficiencies**
- **Cognitive symptoms**
- **Psychiatric comorbidity**
  - Anxiety (40-80%), depression (42-70%), substance use disorders (27-36%)

Functional Impairment

- World Health Organization (WHO) Mental Health Survey Initiative
  - 14 countries
  - Low middle, high middle, and high income
  - N=344 with BED
- Sheehan Disability Scale
  - Assesses illness severity in each of 4 domains

PMC3628997

WHO Mental Health Survey Results

	Any Impairment		Severe Impairment	
	%	(SE)	%	SE
Work	31.2	(3.1)	4.9	(1.4)
Home management	33.9	(3.2)	5.8	(1.5)
Social life	38.1	(3.6)	8.2	(2.1)
Close relationships	35.7	(3.4)	5.4	(1.3)
Any of the above	**46.7**	**(3.4)**	**13.2**	**(2.4)**

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PMC3628997

Challenging Stereotypes

9 Truths About Eating Disorders

Truth 1: Many people with eating disorders look healthy, yet may be extremely ill.

Truth 2: Families are not to blame, and can be the patients' and providers' best allies in treatment.

Truth 3: An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.

Truth 4: Eating disorders are not choices, but serious biologically influenced illnesses.

9 Truths About Eating Disorders

Truth 5: Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.

Truth 6: Eating disorders carry an increased risk for suicide and medical complications.

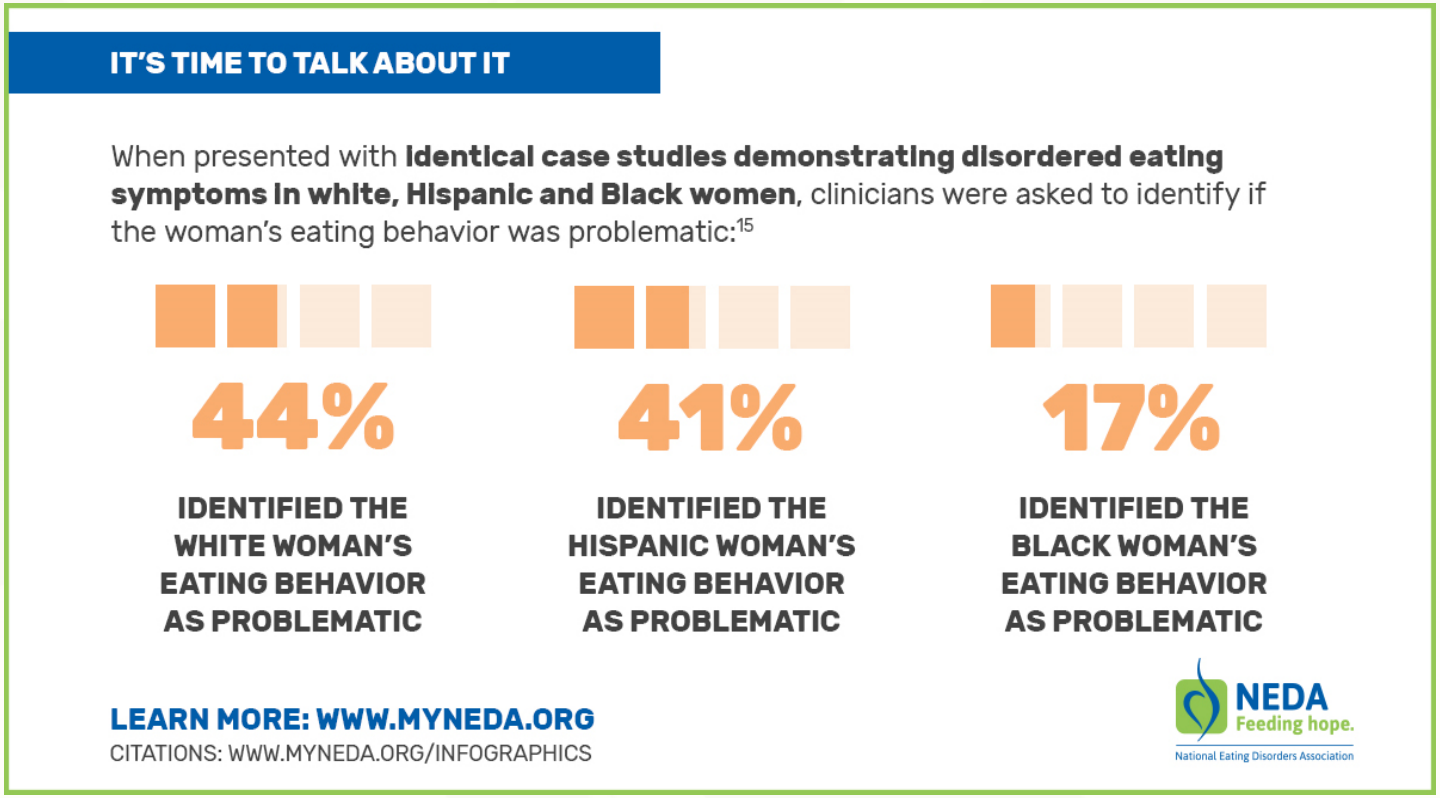
Truth 7: Genes and environment play important roles in the development of eating disorders.

9 Truths About Eating Disorders

Truth 8: Genes alone do not predict who will develop eating disorders.

Truth 9: Full recovery for an eating disorder is possible. Early detection and intervention are important.

Marginalized Populations

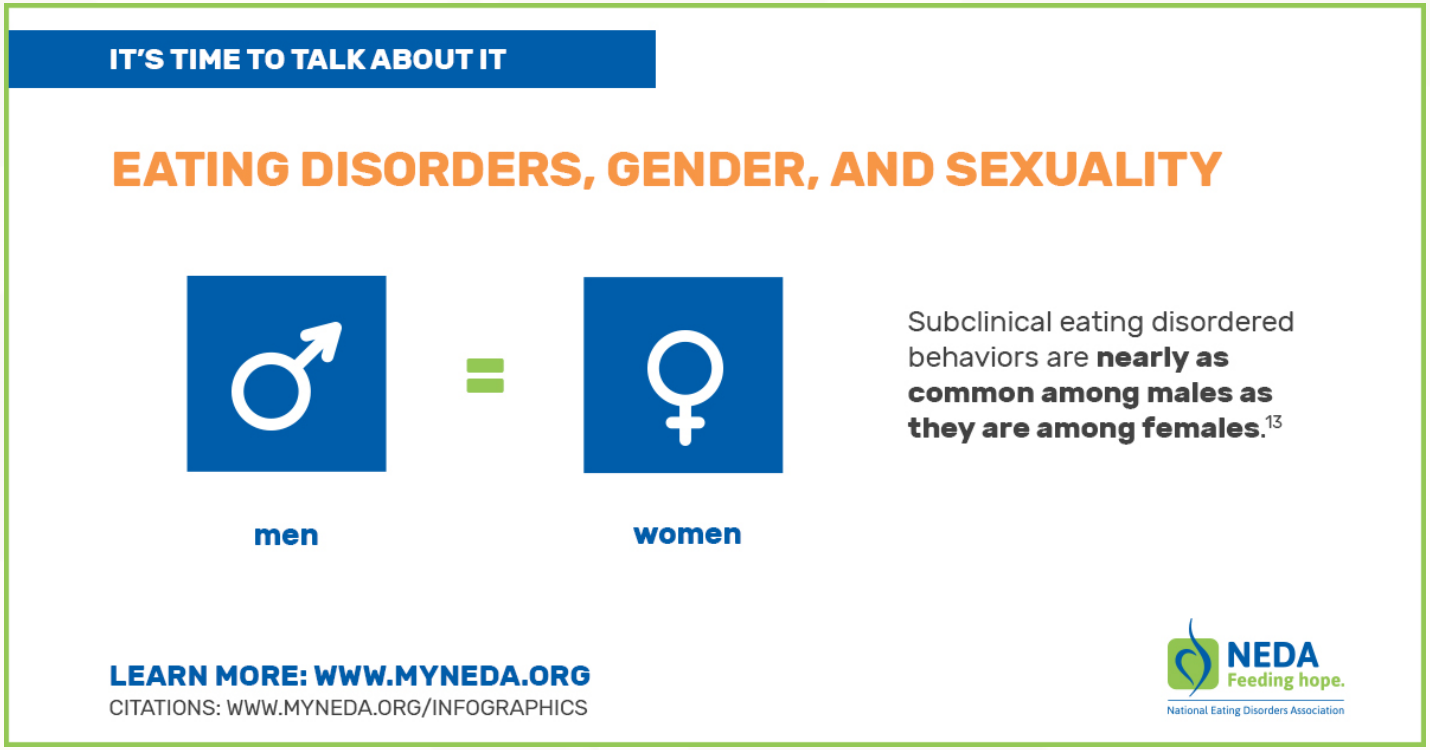


NEDA's Marginalized Voices Project

Marginalized Populations

- BED and/or subthreshold BED is common among racial/ethnic minorities
  - Community samples:
    - 1.4 – 4.5% African-American women
    - 2.3% Latina women
    - BED prevalence among Latina, African-American women > Caucasian
  - Treatment-seeking samples:
    - 33.3% African-American women

Marginalized Populations



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[NEDA's Marginalized Voices Project]

Marginalized Populations

Transgender communities

- 7.4% prevalence among transgender teens/young adults
- Many report greater body dissatisfaction and poor body image
- Transmasculine young people may attempt to diminish breast growth, change their hips, or eliminate menses
- Eating disorders can also co-occur separately and be unrelated to body image concerns

Current State of Affairs

- Eating disorders have the **2nd highest mortality rate** of any psychiatric illness
  - Many due to **suicide**

- **Only 20-57% of those with an eating disorder ever receive treatment.**

- Even if detected, **treatment seeking is challenging**.

Barriers to Detection

- Stereotypes about eating disorders
  - Age
  - Gender
  - Weight
  - Race/ethnicity
- Downplaying of mental health symptoms over physical symptoms
- Reluctance to disclose symptoms

Lack of Insight and Awareness Are Common

- Common misconceptions:
  - *"Only people who need hospitalization have an eating disorder."*
  - *"I can't have an eating disorder. This is what everyone thinks like/eats/worries about."*
  - *"Everyone is on a diet all the time."*
  - *"My lack of period, fainting spells, can't really be that bad."*
  - *"Look! My lab values are fine. This can't be dangerous."*

Early Detection is Key!

- Patients rarely present directly for specialty care
- Primary care/community-based clinic screening advantages:
  - Leveraging existing relationship
  - Kickstarting treatment
  - Ongoing management
- Early diagnosis and treatment = better prognosis

Screening, Brief Intervention, and Referral to Treatment (SBIRT)-ED

does SBIRT-ED work?

The SBIRT-ED tool is easy to use. It helps you quickly screen patients for eating disorders. There is no need to log in or download software. The tool is one click away anytime you need it.

It contains five concise questions (based on the SCOFF questionnaire) to ask any patient. Then it gives you a clear risk rating on the likelihood of whether the individual has an eating disorder.

GET STARTED

Screening for Eating Disorders

- SCOFF (PMC28290)
- Eating Disorder Screen for Primary Care (PMID:28987918)
- Binge-Eating Disorder-7 (PMC4956427)

U.S. version of SCOFF questionnaire.*†

- Do you make yourself vomit because you feel uncomfortably full?
- Do you worry you have lost control over how much you eat?
- Have you recently lost more than 15 pounds in a three-month period?
- Do you believe that you are fat when others say you are too thin?
- Would you say that food dominates your life?

* Reprinted from Behavior Research and Therapy, Vol. 46, Mond and colleagues,[21] Screening for eating disorders in primary care: EDE-Q versus SCOFF, 2008:616, with permission from Elsevier.

† A result is positive if the patient responds "yes" to two or more of the five questions. A positive result indicates that an eating disorder might exist. Rigorous clinical assessment is needed for diagnosis.

Eating Disorder Screen for Primary Care

- Are you satisfied with your eating patterns?*
- Do you ever eat in secret?
- Does your weight affect the way you feel about yourself?*
- Have any members of your family suffered with an eating disorder?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	Yes	No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	Yes	No

Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

Eating Disorder Detection

- Frank discussion of weight/shape concerns
- New onset of restrictive diet
- Changes in weight
- Consideration of comorbid diagnoses
  - Anxiety, depression
  - GI complaints

High Risk Groups to Consider

- Adolescents (12-25 years)
- Patients in key transition periods
- Patients with medical morbidity
  - Polycystic ovarian syndrome
  - Diabetes
  - Gastrointestinal complaints
- Athletes
- Patients with a family history of eating disorders
- Patients seeking help for weight loss
- Veterans

Ongoing Management

An eating disorder is detected or suspected…..what next?

The Role of the PCP

- Initial screening
- Expressing medical concerns and increasing motivation
- Ongoing management (mostly outpatient)
  - Regular visits and communication with team
  - **Consistent messaging is key!**

Referring to Specialty Care

- Refer to a specialty team with eating disorder experience
  - www.eatingdisorderscreener.org
- Be prepared for ambivalence and/or reluctance to accept referral
- Access to eating disorders care is challenging

Challenges: Specialty Eating Disorder Care

- Patient/parent resistance
- Patient/parent schedules
- Coordination of out-of-state care
- Bed availability and long waiting lists
- Insurance coverage
- Providers not using evidence-based practice

Levels of Care

Inpatient	Hospital-based, medically acute
Residential	All day, Less medically acute
Partial Hospitalization (PHP)	Day treatment (M-F)
Intensive Outpatient (IOP)	2-3x/week
Outpatient	~1-2x/week

What Does Treatment Look Like?

- Cognitive-behavioral therapy
  - Identify patterns, negative thoughts, and underlying function of the behavior
- Family-based therapy
  - Parents/guardians deliver treatment
- Pharmacotherapy
  - Lisdexamfetamine for binge-eating disorder
  - Fluoxetine for bulimia nervosa
  - Treatment for comorbid psychiatric conditions

Virtual Treatment

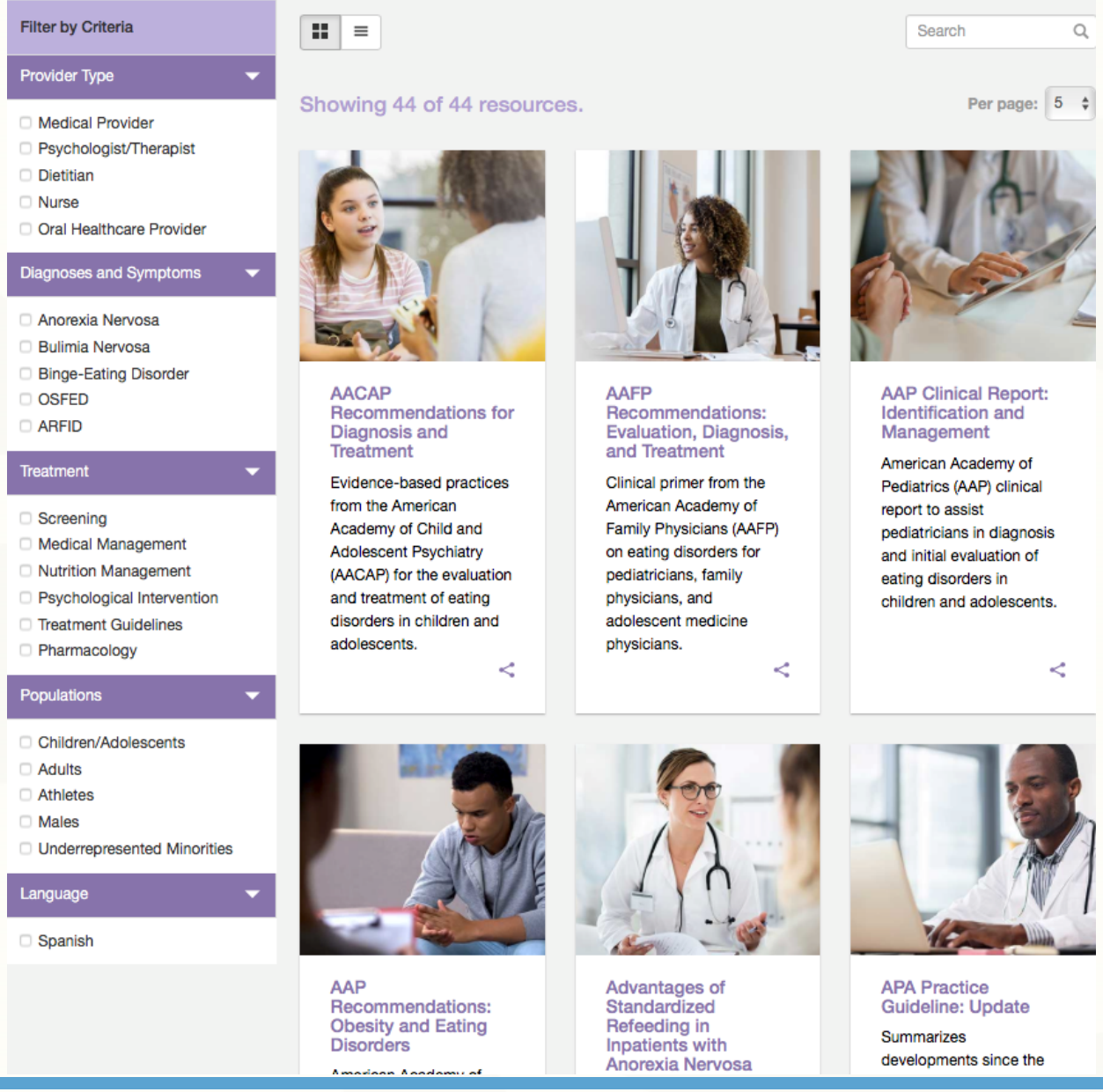
- Pandemic increased access to virtual care
- Several eating disorder groups now provide eating disorder treatment entirely virtually
  - Equip Health, Arise, Within Health

Eating Disorder Treatment is a 4-legged Stool

How to Work with a Specialty Team

- Good communication and consistent messaging is key!
- Work with team to determine a discharge plan (if a higher level of care is needed)
- Understand the difference between referring to a specialty team for evaluation versus treatment
- Be prepared to manage ongoing therapy for comorbidities

Resources



NCEED
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Resource Library with filtering capabilities

CBT-E

CBT-E stands for Enhanced Cognitive Behavior Therapy. It is one of the leading evidence-based treatments for eating disorders, including anorexia nervosa, bulimia nervosa, binge-eating disorder, and other similar states.

This training is offered by the Center for Research on Eating Disorders at Oxford (CREDO).

Cost: Free

Credit: Certificate of completion available

Conceptualizing Eating Disorder Recovery

This webinar was designed to train primary care and behavioral health providers on how to think about eating disorder recovery.

Duration: 1 hour

Cost: Free

Credit: 1 CE Credit or 1 AMA PRA Category 1 Credit

Audience: Primary care and behavioral health providers serving children, adolescents, and young adults

Eating Disorders in Primary Care: Part 1

Eating Disorders 101: This webinar provides foundational knowledge on eating disorders, their signs and symptoms, and methods for detecting them in primary care.

Duration: 1 hour

Cost: Free

Credit: 1 CE Credit or 1 AMA PRA Category 1 Credit

Audience: Primary care and behavioral health providers serving children, adolescents, and young adults

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Training Center with free CME

Questions?

peat@med.unc.edu

Looking for additional trainings?

www.nceedus.org